

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5509
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05500

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle William Last BAILEY		4. DATE OF DEATH Month May Day 29 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1903
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 2 Days 4 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Forman Public Works		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rodney Ellsworth Bailey		14. MOTHER'S MAIDEN NAME Lillie Ridge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1919 - 1925		16. SOCIAL SECURITY NO. 577-12-5627	
17. INFORMANT Mrs. Maud Bailey - #30 Circla Ave, Potomac Hgts.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolus to brain DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes INTERVAL BETWEEN ONSET AND DEATH 2 hrs 4 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. — 19 —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1st 19 61 , to 29 May 19 61 , that (I) (we) last saw the deceased alive on 29 May 19 61 , and that death occurred at 4:10 AM , from the causes and on the date stated above.			
22a. SIGNATURE Arthur O. Woody M.D.		22b. DATE SIGNED 30 May 61	
22c. PHYSICIAN'S NAME (Type) ARTHUR O. WOODY		22d. ADDRESS JACWOOD CLINIC LA PLATA, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Archhart Funeral Home, Inc.		25a. REC'D BY REGISTRAR DATE JUN 2 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

00200

CENTRAL OF DEATH

0000

(M)

(I)

M

Charles

Bureau

May 1910

Report

George H. Brown

M. W.

Associate

Retired

Quinn G. Brown

Adm. Chas. Brown - Reading

I

Quinn G. Brown, 1911, Bureau, (Adm. Chas. Brown - Reading)

1
FOR STATE
HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

361
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5511 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 65502

1. PLACE OF DEATH a. COUNTY <i>Charles</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Bogah</i> c. LENGTH OF STAY in b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bogah (Rural)</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>RONNIE S. BOWMAN</i> First Middle Last				4. DATE OF DEATH <i>5 18 1961</i> Month Day Year			
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-2-61</i> yrs. Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Ulysses BOWMAN</i>				14. MOTHER'S MAIDEN NAME <i>Irene Proctor</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Irene Proctor - Bogah, Md.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>583X HEPATITIS</i> DUE TO (b) <i>INTERVAL BETWEEN ONSET AND DEATH</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>E. J. EDELEN</i> EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>5-19-61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>5/19/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Baptist</i>		22d. LOCATION (City, town, or country) (State) <i>Hill Top, Maryland</i>	
23. FUNERAL DIRECTOR <i>Archard Funeral Home, Inc. Lablady</i> ADDRESS				24a. REC'D BY REGISTRAR <i>MAY 26 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

VS. A15ME
5M 7/59

4000295 XV3



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5512

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY MASON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maysville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS SEX-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NEWTON Middle McMILLIAN Last BROTHERS				4. DATE OF DEATH Month MAY Day 12 Year 19 61			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 MARCH 1894	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper		10b. KIND OF BUSINESS OR INDUSTRY TOBACCO		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William BROTHERS			14. MOTHER'S MAIDEN NAME Mattie VAUGHAN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Maurice Brothers, 464 West Second St. Maysville, Kentucky			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion. 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency. DUE TO (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH 1 minute.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. J. EDELEN		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. EDELEN		DATE SIGNED 5-12-61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-15-61	22c. NAME OF CEMETERY OR CREMATORY Carlisle Cem.		22d. LOCATION (City, town, or county)		(State) Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR DATE MAY 15 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
5513
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

65504

1. PLACE OF DEATH a. COUNTY Charles MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata			c. LENGTH OF STAY IN 1b Issue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Elizabeth Colbert			4. DATE OF DEATH Month Day Year May 29 1961 19		
5. SEX F.	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16 1906		9. AGE (In years last birthday) 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas A. Slye			14. MOTHER'S MAIDEN NAME Elizabeth Milton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address James C. Colbert, Issue, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444X DUE TO Anemia Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) essential hypertension DUE TO (c) essential hypertension					INTERVAL BETWEEN ONSET AND DEATH 1 month 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Issue, Maryland	(State)	
21. I certify that (I) (this hospital) attended the deceased from 5-15 19 61 to 5-29 19 61 , that (I) (we) last saw the deceased alive on 5-28 19 61 , and that death occurred at 10A M, from the causes and on the date stated above.					
22a. SIGNATURE Frédrick M. Johnson MD		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-30-61	
22c. PHYSICIAN'S NAME (Type) Frédrick M. Johnson MD		22d. ADDRESS La Plata, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF June 2, 1961	23c. NAME OF CEMETERY OR CREMATORY Holy Ghost	23d. LOCATION (City, town, or county) (State) Issue, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home		ADDRESS Waldorf, Md.		25a. REC'D BY REGISTRAR JUN 5 '61	25b. REGISTRAR'S SIGNATURE Arthur S. K...

CERTIFICATE OF DEATH

1913

Place of Birth

Sex

Color

Age

Marital Status

Occupation

None

Residence at Time of Death

May 29 1901

Residence at Time of Death

April 10 1906

Part

Clinton County, Mo.

Clinton County, Mo.

Clinton County, Mo.

Clinton County, Mo.

Clinton County, Mo.

Clinton County, Mo.

Clinton County, Mo.

Clinton County, Mo.

Handwritten signature

Handwritten signature

At Test, Mo.

Residence at Time of Death

Clinton County, Mo.

Clinton County, Mo.

Clinton County, Mo.

Clinton County, Mo.

VS. A15ME
5M 7/S9

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5514

Items 8 & 9 Film G200 - 6/5/61 - 1wk

05505

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		e. STATE		b. COUNTY													
Charles		LA PLATA		LIFE		LA PLATA		MD.		CHARLES													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year									
LUTHER						COMBS		5		22		1961											
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.											
M		C		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 2, 1897		63 yrs.		Months		Days		Hours									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?																	
LABORER		ODD JOBS		MARYLAND		U.S.A.																	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME																	
JOHN COMBS						MARTHA STONE																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or not known) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT											
NO												MRS. MARTHA JOHNSON, LA PLATA, MD.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														INTERVAL BETWEEN ONSET AND DEATH 5-22-61									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)											
BURIAL				5-27-61				NEWTOWN METH				LA PLATA, MARYLAND											
23. FUNERAL DIRECTOR								24a. REC'D BY REGISTRAR								24b. REGISTRAR'S SIGNATURE							
The Hunt Funeral Home, Waldorf, MD								MAY 31 '61								Arthur S. Thomas							

100-100000-100000



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5515 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05506

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PIATA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physician Memorial		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle C. Last COOKSEY		4. DATE OF DEATH Month May Day 14 , Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 17, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HAWKINS		14. MOTHER'S MAIDEN NAME COOKSEY MARY JEANETTE ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-36-3538	
17. INFORMANT Francis Walter, Hughesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis and Left Hemothorax 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple fractured ribs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of window	
20c. TIME OF INJURY Month, Day, Year 3:00 PM 5/12 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hughesville, Charles, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/15/61	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-16-61	22c. NAME OF CEMETERY OR CREMATORY MT REST	22d. LOCATION (City, town, or county) (State) LA PIATA, MD.
23. FUNERAL DIRECTOR The Hunt Funeral Home, W. H. Hout, Md.		24a. REC'D BY REGISTRAR MAY 17 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No. 05507

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA				c. LENGTH OF STAY IN TB 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL HOSP.				e. STREET ADDRESS Spring Hill			
3. NAME OF DECEASED (Type or print) First Middle Last Farrar William COOKSEY				4. DATE OF DEATH Month May Day 15 Year 1961			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 May 1870	9. AGE (In years lost birthday) 91 yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Cooksey				14. MOTHER'S MAIDEN NAME Sussie Elizabeth Cash			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Susie Iola Barbour - La Plata, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Collyrium DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 mos. 10 days. 10 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign tumor prostate							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from June , 1951, to 15 May , 1961, that I last saw the deceased alive on 15 May , 1961, and that death occurred at 11:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur O. Coondy M.D.				ADDRESS (Street, city or town, state) JARWOOD CLINIC DATE SIGNED 16 May 61			
PHYSICIAN'S NAME (Type) ARTHUR O. COONDY				LAPLATA			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/61		22c. NAME OF CEMETERY OR CREMATORY Trinity		22d. LOCATION (City, town, or county) (State) Newport Md	
23. FUNERAL DIRECTOR'S SIGNATURE Archibut Inc Laplata Md				24a. REC'D BY REGISTRAR DATE MAY 22 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

is necessary, If an funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>5517</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>65508</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> </div> </div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)</div> <div>a. STATE</div> </div> </div>											
<div>Charles</div>				<div>MARYLAND</div>							
<div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Bryans Road</div>				<div>c. LENGTH OF STAY IN</div> <div>1b</div>							
<div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div>				<div>Bryans Road (Rural)</div>				<div>d. STREET ADDRESS</div>			
<div>3. NAME OF DECEASED (Type or print)</div> <div>KATIE</div>				<div>First Middle Last</div> <div>O. COX</div>				<div>4. DATE OF DEATH</div> <div>Month Day Year</div> <div>May 16 61</div>			
<div>5. SEX</div> <div>Female</div>		<div>6. COLOR OR RACE</div> <div>Colored</div>		<div>7. MARRIED</div> <div><input checked="" type="checkbox"/> NEVER MARRIED</div> <div><input type="checkbox"/> WIDOWED</div> <div><input type="checkbox"/> DIVORCED</div>		<div>8. DATE OF BIRTH</div> <div>November 29, 1908</div>		<div>9. AGE (In years last birthday)</div> <div>52 yrs.</div>		<div>IF UNDER 1 YEAR</div> <div>Months Days Hours Min.</div>	
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>House wife</div>				<div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>At Home</div>				<div>11. BIRTHPLACE (State or foreign country)</div> <div>Alabama</div>			
<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>				<div>13. FATHER'S NAME</div> <div>Walter Ousley</div>				<div>14. MOTHER'S MAIDEN NAME</div> <div>Viola Corklile</div>			
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</div> <div>No</div>				<div>16. SOCIAL SECURITY NO.</div> <div>577-26-1400</div>				<div>17. INFORMANT</div> <div>James Cox - Box 210 Bryans Road, Maryland</div>			
<div>18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).]</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Pontine H emorrhage.</div> <div>331X</div> <div>331X</div> <div>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.</div> <div>DUE TO (b)</div> <div>DUE TO (c)</div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div>											
<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>											
<div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTORY <input type="checkbox"/> CAUSE OF DEATH.</div>				<div>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)</div>							
<div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour e.m. p.m.</div> <div>19</div>				<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div>				<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>			
<div>20f. (City or town)</div> <div>(County)</div> <div>(State)</div>				<div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div>							
<div>ACTUAL SIGNATURE</div> <div>EXAMINER'S NAME (Type)</div> <div>Charles S. Petty, M.D.</div>				<div>CHIEF MEDICAL EXAMINER</div> <div>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER</div>				<div>DATE SIGNED</div> <div>5/16/61</div>			
<div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>				<div>22b. DATE THEREOF</div> <div>5/25/1961</div>				<div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>Mt. Hope Church Cemetery</div>			
<div>22d. LOCATION (City, town, or country)</div> <div>(State)</div> <div>Nanjemoy, Maryland</div>				<div>23. FUNERAL DIRECTOR</div> <div>ADDRESS</div> <div>Archart Funeral Home, Inc. - La Plata, Md.</div>							
<div>24a. REC'D BY REGISTRAR</div> <div>DATE</div> <div>MAY 26 '61</div>				<div>24b. REGISTRAR'S SIGNATURE</div> <div>Charles S. Petty</div>							

FOR STATE
DEATH CERTIFICATE
No. 1

AMERICAN STATE DEPARTMENT OF HEALTH
BUREAU OF STATISTICAL RESEARCH AND RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: **Charles**
2. SEX: **Male**
3. AGE: **30**
4. DATE OF BIRTH: **May 10, 1901**
5. PLACE OF BIRTH: **St. Louis, Mo.**
6. OCCUPATION: **None**
7. CAUSE OF DEATH: **Heart Disease**
8. MANNER OF DEATH: **Natural**
9. SIGNATURE OF EXAMINER: **John H. Johnson**
10. DATE OF EXAMINATION: **May 15, 1931**

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE MEDICAL EXAMINER, ST. LOUIS, MISSOURI, AND A COPY IS TO BE FURNISHED TO THE BUREAU OF STATISTICAL RESEARCH AND RECORDS, DEPARTMENT OF HEALTH, ST. LOUIS, MISSOURI.

CERTIFICATE OF DEATH

Reg. Dist. No. 5509

5518

1. PLACE OF DEATH o. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CHARLES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUGHESVILLE				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES DRUSCILLA GOOD				4. DATE OF DEATH Month Day Year MAY 5, 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 16, 1908	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ABE GOLDSMITH				14. MOTHER'S MAIDEN NAME IDA GOLDSMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address EDWIN C. GOOD, HUGHESVILLE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma 260X DUE TO Diabetes Mellitus. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemachromatosis DUE TO (c) 5-6 yrs				INTERVAL BETWEEN ONSET AND DEATH 4 days Yr 5-6 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from May 3, 1961 , to May 5, 1961 , that I last saw the deceased alive on May 3, 1961 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE V. M. SERON MD. M.D.				ADDRESS (Street, city or town, state) Waldorf, Md			
PHYSICIAN'S NAME (Type) V. M. SERON MD.				DATE SIGNED 5/6/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-8-61		22c. NAME OF CEMETERY OR CREMATORY OLD FIELDS		22d. LOCATION (City, town, or county) (State) HUGHESVILLE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, MD				ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 11 '61	
				24b. REGISTRAR'S SIGNATURE Charles E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Items 18-21 Film 288
6-15-61 ams

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05510

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mason Springs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mason Springs (Rural)	
c. LENGTH OF STAY in lb Star Route # 2 La Plata, Md.		d. STREET ADDRESS Star Route #2 La Plata, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE MAE GRINDER		4. DATE OF DEATH Month Day Year May 22 19 61	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13, 1917	
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days 44	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy Helsel		14. MOTHER'S MAIDEN NAME Olive Barton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) No		16. SOCIAL SECURITY NO. 207 - 22 - 1411	
17. INFORMANT Mr. Augustus Grinder - Star Route #2 La Plata		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning, secondary to overingestion of intermediate -acting barbiturates 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned in pond	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:30 PM 5/22/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pond		20f. (City or town) (County) (State) -- Charles Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED May 23, 1961			
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		M.D.	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/1961	
22c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens		22d. LOCATION (City, town, or country) (State) Waldorf, Maryland	
23. FUNERAL DIRECTOR Archart Funeral Home, Inc.		24a. REC'D BY REGISTRAR MAY 31 '61	
ADDRESS Archart Funeral Home, Inc. La Plata, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



100

CERTIFICATE OF DEATH

Reg. Dist. No.

5520

05511

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		d. STREET ADDRESS Old Indian Head Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nettie Hardy		4. DATE OF DEATH 5-1-61	
5. SEX Female		6. COLOR OR RACE W-US	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-14-1884	
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR 82 yrs. Months 86 Days 86 Hours 86 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas O. Hodges		14. MOTHER'S MAIDEN NAME Nancy Hall Pomonkey Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Bessie Keller		18. ADDRESS 7-Kenwood Place Indian Head Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Decompensation 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Valvular Disease-Cardiac DUE TO (c) Senility-Arterio Sclerosis General		INTERVAL BETWEEN ONSET AND DEATH 3-Days Indefinite Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-10-55 , 19 55 , to 5-1-61 , 19 61 , that I last saw the deceased alive on 5-1-61 , 19 61 , and that death occurred at 3-50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17-Potomac Ave-Indian Head Md DATE SIGNED 5-2-61			
ACTUAL SIGNATURE James E. Andrews		PHYSICIAN'S NAME (Type) James E. Andrews	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/5/1961	
22c. NAME OF CEMETERY OR CREMATORY Bunby Oak Cemetery		22d. LOCATION (City, town, or county) (State) Pomonkey, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc. La Plata, Maryland		24a. REC'D BY REGISTRAR MAY 4 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kincaid			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form D-1 (Rev. 1-1-60)

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. RACE [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. OCCUPATION [REDACTED]		9. CAUSE OF DEATH [REDACTED]	
10. DATE OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. SIGNATURE OF DECEASED [REDACTED]	
13. SIGNATURE OF WITNESS [REDACTED]		14. SIGNATURE OF PHYSICIAN [REDACTED]		15. SIGNATURE OF CORONER [REDACTED]	
16. SIGNATURE OF REGISTRAR [REDACTED]		17. SIGNATURE OF CLERK [REDACTED]		18. SIGNATURE OF OFFICIAL [REDACTED]	

DATE _____

VS. AISME
5M 9/60

1
RECEIVED
FBI NEW YORK
JAN 10 1964

INVESTIGATION OF DEATH

NAME: [REDACTED] SEX: [REDACTED] AGE: [REDACTED] RACE: [REDACTED]

DATE OF DEATH: [REDACTED] TIME OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED]

CAUSE OF DEATH: [REDACTED]

REPORTED BY: [REDACTED] RELATIONSHIP: [REDACTED]

DATE OF REPORT: [REDACTED]

REPORTING OFFICE: [REDACTED]

INVESTIGATING OFFICER: [REDACTED]

DATE OF INVESTIGATION: [REDACTED]

LOCATION OF INVESTIGATION: [REDACTED]

STATUS: [REDACTED]

REMARKS: [REDACTED]

TO: SAC, NEW YORK (100-388610) FROM: SAC, NEW YORK (100-388610) (P)

SUBJECT: [REDACTED]

RE: [REDACTED]

100-388610-1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5522

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) MATTHEW MADISON MUSCHETTE			4. DATE OF DEATH MAY 25, 1961		
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1916	9. AGE (In years last birthday) 45 yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME Anthony Muschetti			14. MOTHER'S MAIDEN NAME Elyzabeth Hill		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 212-16-5255		17. INFORMANT LORETTA MUSCHETTE, LA PLATA, MD.	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5-25-61					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE E. J. Edelen		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-25-61	
EXAMINER'S NAME (Type) E. J. EDELEN		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-29-61		22c. NAME OF CEMETERY OR CREMATORY St. Josephs	
22d. LOCATION (City, town, or county) (State) Pomfret, MD					
23. FUNERAL DIRECTOR'S SIGNATURE Herbert Funeral Home		ADDRESS Waldorf Md		24a. REC'D BY REGISTRAR DATE MAY 31 '61	
				24b. REGISTRAR'S SIGNATURE Charles S. Harris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5523

CERTIFICATE OF DEATH

Reg. Dist. No. 05514

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburgh (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital				d. STREET ADDRESS Avening Farm			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle STODDERT Last REEDER				4. DATE OF DEATH Month May Day 20 , Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 6, 1880		9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Winchester, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Reeder				14. MOTHER'S MAIDEN NAME Margaret Mc Cormack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Foster Reeder - Box #153 Newburgh, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Massive Pulmonary Embolism 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 10 MIN'S.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 19 61 , to May 20 19 61 , that I last saw the deceased alive on May 20 , 19 61 , and that death occurred at 3:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Md DATE SIGNED 5-20-61 ACTUAL SIGNATURE J. PARRAN JARBOE M.D. PHYSICIAN'S NAME (Type) J. PARRAN JARBOE M.D. La Plata, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/1961		22c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		22d. LOCATION (City, town, or county) (State) Wayside, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc. ADDRESS Archart Funeral Home, Inc. - La Plata, Md.				24a. RECEIVED BY REGISTRAR DATE MAY 26 61		24b. REGISTRAR'S SIGNATURE William S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No. 05515

MEDICAL CERTIFICATION

5525

CERTIFICATE OF DEATH

Reg. Dist. No. 05516

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf - Rural c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf - Rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALTON Middle BONEVENTURE Last WADE		4. DATE OF DEATH Month May Day 18 Year 61	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1888 9. AGE (In years lost birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Hillary Wade		14. MOTHER'S MAIDEN NAME Martha Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-14-3351	17. INFORMANT Address Alice Wade, Waldorf, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 420.1 DUE TO Cornary Ischemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Chronic Cornary Disease (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 min 1 mo years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 8, 1961 , to May 18, 1961 , that I last saw the deceased alive on May 13, 1961 , and that death occurred at 8:20 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Waldorf, Md DATE SIGNED 5/19/61 ACTUAL SIGNATURE Vaher M. Seron M.D. Aguas PHYSICIAN'S NAME (Type) VAHER M. SERON MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-22-61	22c. NAME OF CEMETERY OR CREMATORY St Peters	22d. LOCATION (City, town, or county) (State) Waldorf, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The Hunt Funeral Home, Waldorf, Maryland		24a. REC'D BY REGISTRAR DATE MAY 23 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville-Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville - Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JANIS Middle Cecelia Last WADE				4. DATE OF DEATH Month MAY Day 10 Year 1961			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1881	
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Sembley				14. MOTHER'S MAIDEN NAME Rebecca Greenfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Ursuline Swann, Waldorf, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, RIGHT DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) ESSENTIAL HYPERTENSION DUE TO (c) GENERALIZED ARTERIO SCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH 10 days. 12 years. 15 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 17, 1948 to MAY 10, 1961 , that (I) (we) saw the deceased alive on MAY 9, 1961 , and that death occurred at 10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE John H. Griffin				22b. DATE SIGNED 5/10/61		22c. PHYSICIAN'S NAME (Type) JOHN H. GRIFFIN M.D.	
22d. ADDRESS Hughesville, Maryland				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-13-61		23c. NAME OF CEMETERY OR CREMATORY St Marys		23d. LOCATION (City, town, or county) (State) Bryantown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				25a. REC'D BY REGISTRAR DATE MAY 16 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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FOR STATE
HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a body is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in items 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5527

05518

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Charles Street (Route #6)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First XAVIER Middle WATTS Last WATTS		4. DATE OF DEATH Month 5 Day 27 Year 1961	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. ? , 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9. AGE (in years last birthday) 59 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Watts		14. MOTHER'S MAIDEN NAME Liza Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Augustus Watts - La Plata, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause, per item for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) CRUSHED HEAD & CHEST			
DU TO 812X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HIT BY TWO AUTOS			
DU TO 5-27-61			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) HIT BY 2 AUTOS - PEDESTRIAN	
20c. TIME OF INJURY Month, Day, Year 9:30 p.m. 5-27-61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) AWAY RT 6	20f. (City or town) (County) (State) LA PLATA MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. J. EDELEN		M.D.	
EXAMINER'S NAME (Type) E. J. EDELEN		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) LA PLATA CHAS MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/30/1961	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Church	22d. LOCATION (City, town, or county) (State) La Plata Maryland
23. FUNERAL DIRECTOR Archard Funeral Home, Inc. La Plata, Md.		24a. REC'D BY REGISTRAR MAY 31 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00518

FILE NO.

(M)

CHAS. J.

WATTS

XAVIER

CHARLES HENDY

W. J. BY THE ALICE

W. J. BY THE ALICE

W. J. BY THE ALICE

W. J. BY THE ALICE

(1)

1
FOR STATE
HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5528 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

055119

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville, Md.				c. LENGTH OF STAY IN 1b Hughesville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home of Midwife, Catherine Dorsey				d. STREET ADDRESS Hughesville			
3. NAME OF DECEASED (Type or print) Infant John Francis Woodland				4. DATE OF DEATH Month 5 Day 15 Year 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-15-'61	
9. AGE (in years last birthday) 30		IF UNDER 1 YEAR Months 30 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Male				10b. KIND OF BUSINESS OR INDUSTRY Negro			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Mason Jenifer				14. MOTHER'S MAIDEN NAME Sarah Elizabeth Woodland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No			
17. INFORMANT Catherine Dorsey, Hughesville, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Aspiration of Aminiotic Fluid 7620 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cried spontaneously but had lots of blood & fluid from mouth INTERVAL BETWEEN ONSET AND DEATH 30 min							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E. J. Edelen, M.D.				DATE SIGNED 5-15-'61			
EXAMINER'S NAME (Type) E. J. Edelen, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-15-61			
22c. NAME OF CEMETERY OR CREMATORY Family Cemetery				22d. LOCATION (City, town, or country) (State) Mechanicsville, Md			
23. FUNERAL DIRECTOR Hunt Funeral Home				24a. REC'D BY REGISTRAR Waldoy			
ADDRESS Waldoy				24b. REGISTRAR'S SIGNATURE Arthur L. Hunt			

4000463XV6

05519

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27



Charles

Maryland

Charles

Frederick

Home of Minnie, Catherine Dwyer

Woodland

5-12-1917

Maryland

Charles Dwyer, Woodland

Catherine Dwyer, Frederick

Frederick, Catherine Dwyer

Caused a catheterization and loss of blood & fluid from wound

5-12-1917

E. V. Nelson, M.D.